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MEDICAL HISTORY
PEDIATRIC

Patient Name_____**Date of Birth**_____**Today's Date**_____

Please complete both sides of this form. This information is helpful to us in caring for your child in understanding your family environment.

Age of your home_____ Does your child drink: well water □ City Water □ Other _____

Please list all those living in your child's home.

Name	Relationship to child	Date of birth	Occupation

Please list other immediate family (Parent, siblings, stepparent etc.) not living in home.

Name	Relationship to child	Date of birth	Occupation

PAST MEDICAL HISTORY

Please describe any of the following about your child:

Problems with pregnancy/delivery (cesarean birth/premature/etc.)?_____
Problems as newborn-special care nursery? _____
Surgeries _____
Other Hospitalizations _____
Chronic/Ongoing illnesses _____
Allergies(medication, food, seasonal) _____
Developmental/behavioral problems
Specialists _____
Injuries or accidents _____

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MEDICAL HISTORY
PEDIATRIC

Family History (biological parents, grandparents, aunts, uncles of your child) Please circle or explain disorders if you check "yes" and indicate relationship to your child.		**Indicate when form was updated.**
Heart Disease before age 50 (Heart attack, stroke, hypertension, high cholesterol, sudden cardiac death, etc.)	☐ Yes ☐ No	
Endocrine Disorder (diabetes beginning in childhood, thyroid problems, etc.)	☐ Yes ☐ No	
Birth defects/Genetic disease (Congenital heart disease, Down Syndrome, Tay Sachs)	☐ Yes ☐ No	
Cancer (if yes, type and age of diagnosis)	☐ Yes ☐ No	
Neurological Disorder (seizures, tics, migraines)	☐ Yes ☐ No	
Blood/bleeding disorder (Sickle cell, clotting disorders, etc)	☐ Yes ☐ No	
Lung disease (Asthma, tuberculosis, cystic fibrosis)	☐ Yes ☐ No	
Kidney disorder (hydronephrosis, nephritic syndrome, kidney stones, need for dialysis)	☐ Yes ☐ No	
Digestive disorder (Crohn's Disease, celiac disease, acid reflux, ulcers, colitis)	☐ Yes ☐ No	
Liver disorder (hepatitis, jaundice)	☐ Yes ☐ No	
Bone or joint disorder (arthritis, lupus)	☐ Yes ☐ No	
Muscle/nerve disorder (muscular dystrophy, multiple sclerosis)	☐ Yes ☐ No	
Developmental (autism, delays in development)	☐ Yes ☐ No	
Learning disabilities (ADHD, Dyslexia)	☐ Yes ☐ No	
Psychiatric/behavioral disorders (anxiety, bipolar disorder, depression, etc.)	☐ Yes ☐ No	
Substance abuse (alcohol, drugs) **Tobacco use**	☐ Yes ☐ No	
Nutrition (Overweight, failure to thrive)	☐ Yes ☐ No	
Please describe other problems/information you would like us to know about your family:		